

the other hand, since the comfort of the patient is of paramount importance, opium derivatives or analogues and sedatives should not be withheld when other measures are no longer of avail. Recently demerol has been found to induce satisfactory pain relief, in some instances, without many of the well-known physiologic disadvantages of the opiates. For oropharyngeal lesions, local anesthetics, such as orthoform or cocaine, are helpful. Numerous medicaments have been sponsored as panaceas for the pain of advanced malignancies, the majority of which are the subjects of conflicting descriptions concerning their usefulness. Cobra venom falls into this class of substances which cannot be said to offer uniform palliation. Other preparations which have had considerable vogue but seemingly fail in the majority of cases are colloidal lead and gold solutions and Coley toxin. Recent trial of H 11 and heptaldehyde has been relatively fruitless."

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PRIMROSE, E. J. R., AND ANDERSON, A. B.: *Anaesthetic Convulsions*. Glasgow M. J. 144: 16-19 (July) 1945.

"The etiology of the so-called 'ether convulsions' has been the subject of much speculation since the first description of this condition in 1927. . . . In . . . two cases, practically all the factors which have been considered as predisposing to ether convulsions were present, namely: a young patient; a septic condition; high atmospheric temperature; pre-anaesthetic medication with atropine, and impurities in the ether. What part these impurities in the anaesthetic played in precipitating the convulsions cannot be determined with certainty, but we are inclined to attribute a major share to this factor in view of the rare occurrence of convulsions in the large number of operations performed in the

[Glasgow Royal] Infirmary where the other factors have been present. If this hypothesis be accepted, the results of the fractional distillation of the impure ether suggest that warming the ether with hot water was responsible for the convulsions in these two cases. Undoubtedly ether containers on Boyle machines should be cleaned out frequently." 2 references.

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MORTON, H. J. V.: *The Force of Expiration as a Sign in Anaesthesia (Abbreviated)*. Proc. Roy. Soc. Med. 38: 441-446 (June) 1945.

"One relatively neglected aspect of respiratory activity is the study of the changes which occur in the nature of expiration and particularly the force of expiration during anaesthesia. Inspiration is an active process depending, chiefly, on the activity of the intercostals and diaphragm. With each inspiratory movement the muscles of the anterior abdominal wall relax sufficiently to provide room for the displaced viscera as the diaphragm descends. 'Passive' expiration is effected by a combination of the 'elastic recoil' of the thoracic walls and actual muscular control. Increasingly 'active' expiration involves increasingly powerful contractions of the abdominal muscles. The force of expiration is clearly a very variable quantity. How may this force be measured and what is the significance of changes which occur in it during anaesthesia? . . . The maximum expiratory pressure which can be achieved by voluntary effort depends on vital capacity, physique, and physical fitness. Here one may deal with figures well in excess of 100 mm. Hg. Pressures of this high order, naturally, do not occur during anaesthesia, and it is more relevant to inquire what kind of pressure develops when opposition is offered to merely 'passive' expiration.